



PATIENT

Jagger Schneider

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

12 Years 2 Months

WEIGHT

12.4 Pounds

INTERPRETED BY

Beth Johnson, DVM,
DACVIM (SAIM)

IMAGING PERFORMED BY

Vincent Ravancho,
CVT

HOSPITAL NAME

Denville AH

REFERRING VET

Dr. Reddy

INVOICE

37146

DATE

5/19/26

PRESENTING CLINICAL SIGNS

History: R/o infiltrative small intestinal disease/mass/systemic illness/food sensitivity. Pet is lethargic and stressed w/ less activity and faint purring. Excessive vomiting consistency of undigested food. Pet not currently eating.

Abnormal PE/Chem/CBC/UA Results: Neut High, Lym low, Phos low.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with occasional echogenic non-shadowing debris, most consistent with exfoliated cells, mucous and/or small blood clots, as well as dependent mineral "sand" (crystals) debris. Both sterile inflammation as well as urinary tract infection can present with echogenic debris. No masses are observed. Small discrete cystoliths cannot be definitively ruled out. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Left kidney is normal in size (4.2 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Right kidney is normal in size (4.1 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

Left adrenal gland is normal in size (0.5 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.5 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size (1.1 cm thick at the hilus) with a mildly swollen but smooth capsule. Parenchyma is normal and homogenous in echogenicity and echotexture. No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

Liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal



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The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

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The visible small intestine demonstrates areas of mildly thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen of the small intestine is mildly distended with very echogenic reverberation artifact from intraluminal gas. There is no evidence of obstruction, foreign material, or infiltrative disease; however, visualization is partially inhibited by gas.

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In the right cranial abdomen, appearing to involve the ileoceocolic junction is an irregular, approximately 2.6 cm in size, homogenous hypoechoic mass. The remaining colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

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The pancreas that is observed appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

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Free Abdomen

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There is no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

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CVT

- The suspect ileoceocolic junction mass is most concerning for infiltrative neoplasia such as round cell neoplasia, i.e., lymphoma, versus carcinoma, versus other. A benign inflammatory process cannot be ruled out but is considered less likely.
- Diffusely mild/emerging inflammatory bowel disease pattern- Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No loss of layering or distinct characteristics of malignancy are present. Therefore, differentials cannot be further ranked without tissue sampling. This finding, however, can be in part normal patient variant in senior cats.
- Splenomegaly- can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, amyloidosis, as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.
- Urinary bladder mineral/debris +/- small cystoliths

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI



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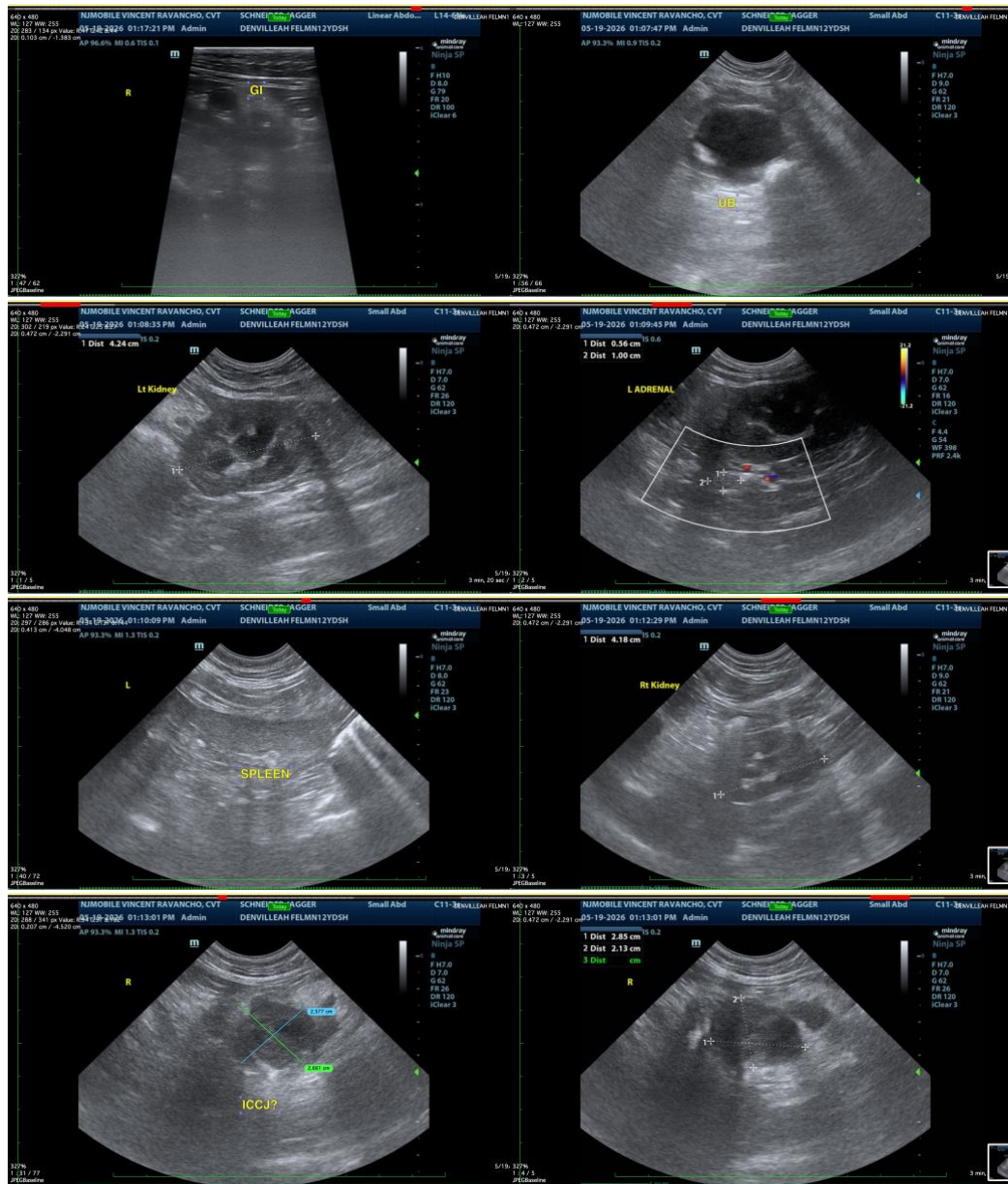
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Laboratory is recommended for further evaluation of GI and pancreatic function.

Fine needle aspirates of the suspect ileoceocolic junction mass and spleen could be considered if patient's coagulation status is appropriate.

Alternatively, or if a cytologic diagnosis is unable to be obtained, an exploratory laparotomy for planned resection and anastomosis of the mass and biopsies of the remaining GI tract could be considered. However, if pursued, given the suspected location of the mass, consultation with a veterinary surgeon is recommended.





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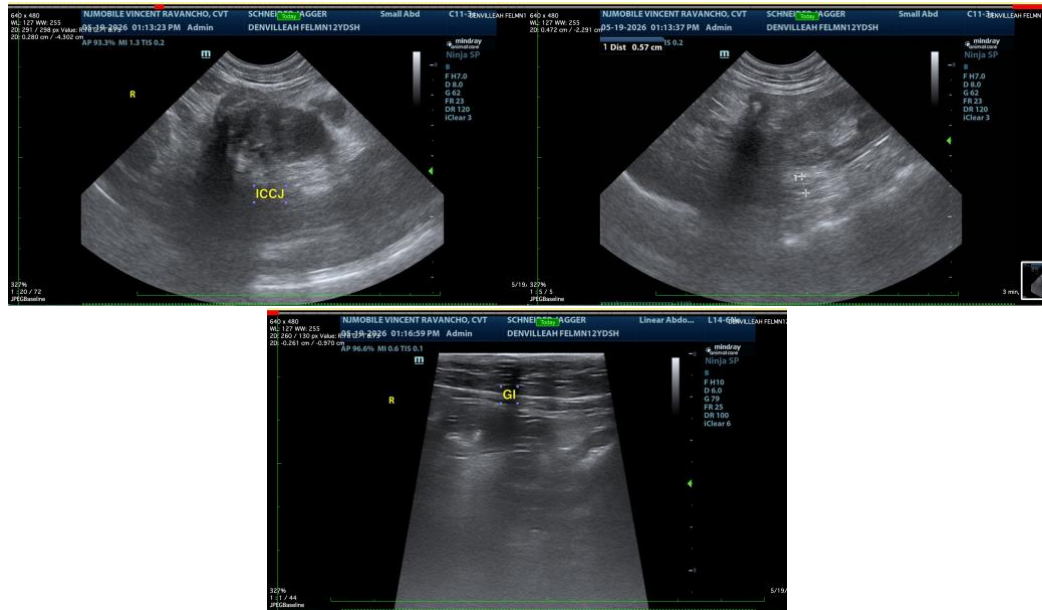
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

Beth Johnson, DVM DACVIM

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